
*Full Item Register Number [auto]* **CF/RAI/NYHQ/SP/SSC/2001-00800**

*Ext Ref: Doc Series/Year/Number*

*Record Item Title*

**Children and Development in the 1990s: A UNICEF sourcebook - on the occasion of the World Summit for Children (1990: 28-29 September). Part 1 of 6. Pp 1-38 (plus cover and inner cover notes and introduction). Total 266 pages**

| *Date Created / on Correspondence* | *Date Registered* | *Date Closed* |
|---|---|---|
| 29-Sep-1990 | 28-Dec-2001 | 30-Sep-1990 |

| | |
|---|---|
| *Primary Contact* | **Rijuta Tooker (Temp Assist)** |
| *Owner Location* | **Special Session & Global Movement For Chil =** |
| *Home Location* | **Special Session & Global Movement For Chil =** |
| *Current Location* | **Special Session & Global Movement For Chil =** |

*Fd1: Type: IN, OUT, INTERNAL*
*Fd2: Sender Ref or Cross Ref*
*Field 3*

| | |
|---|---|
| *File Container Record ID* | **CF/RAF/USAA/DB01/2001-06648** |
| *File Container Record (Title)* | **Background Documents (WSC)** |

| *N1: Number of pages* | *N2: Doc Year* | *N3: Document Number* |
|---|---|---|
| 48 | 0 | 0 |

*Full GCG Code Plan Number*
*Record GCG File Plan*

| *Da1: Date Published* | *Da2: Date Received* | *Date 3* | *Priority* |
|---|---|---|---|
| | | | |

*Record Type* **A01ed Item Spec Proj - CF/RAI/NYHQ/SP/SSC**

*DOS File Name*

*Electronic Details* **No Document**

---

*Alt Bar code = RAMP-TRIM Record Number* **CF/RAI/NYHQ/SP/SSC/2001-00800**

*Notes*
*29-30 September 1990, United Nations, New York. ISBN 92-806-0056-7*

| **Print Name of Person Submit Images** | **Signature of Person Submit** | *Number of images without cover* |
|---|---|---|
| Paulette Spencer | Paulette Spencer | 48 |

# Children and Development in the 1990s
# a UNICEF sourcebook

on the occasion of

# the World Summit for Children

29-30 September 1990
UNITED NATIONS, NEW YORK

*The following persons, in alphabetical order, contributed to this Sourcebook:*

Ranjit Atapattu, Mansoor Ahmed, Agnes Aidoo, Mark Belsey, Dieter Berstecher, Vesna Bosnjak, Joseph Christmas, Kathleen Cravero, Carel de Rooy, Nigel Fisher, Kul Gautam, Peter Greaves, Stephanie Griffith-Jones, Khadija Haq, Terrel Hill, Richard Jolly, Gareth Jones, Susi Kessler, Margaret Kyenkya-Isabirye, Eva Jespersen, Robert Ledogar, Per Miljeteig-Olssen, Robert Myers, William Myers, Nyi Nyi, Samuel Ofosu-Amaah, Elizabeth Preble, James Sherry, Clarence Shubert, and Rolph van der Hoeven.

*Editorial work was done by:*

Nancy Borman, Leo Goldstone, Brian Kelly, Patricia Lone, Aya Okada, Priscilla Scherer, Ian Steele, Cynthia Wallace, and Jin Wei under the overall co-ordination of Robert Ledogar.

*Production was done by:*

Peter David and Dee Foord-Kelcey and Design by Creative Partners.

UNICEF gratefully acknowledges the collaboration of colleagues in WHO and UNESCO who contributed both substantively and editorially to this volume.



*ISBN 92-806-0056-7*

# Children and Development in the 1990s
# a UNICEF sourcebook

on the occasion of

## the World Summit for Children

29-30 September 1990
UNITED NATIONS, NEW YORK

BLANK
PAGE

# Table of contents

## Country data tables



## Other tables

## Charts and graphs

# Acronyms

| | |
|---|---|
| ACC/SCN | Administrative Committee on Co-ordination (of the United Nations) – Subcommittee on Nutrition |
| AIDS | Acquired Immunodeficiency Syndrome |
| ARI | Acute Respiratory Infections |
| BCG | Anti-tuberculosis Vaccine |
| CSDR | Child Survival and Development Revolution |
| DAC | Development Assistance Committee (of OECD) |
| DPT | Combined Diphtheria/Pertussis/Tetanus Vaccine |
| EPI | Expanded Programme on Immunization |
| FAO | Food and Agriculture Organization |
| GDP | Gross Domestic Product |
| GNP | Gross National Product |
| HIV | Human Immunodeficiency Virus |
| IDD | Iodine Deficiency Disorders |
| ILO | International Labour Organisation |
| IMF | International Monetary Fund |
| IMR | Infant Mortality Rate |
| MMR | Maternal Mortality Rate |
| ODA | Official Development Assistance |
| OECD | Organisation for Economic Co-operation and Development |
| ORS | Oral Rehydration Salts |
| ORT | Oral Rehydration Therapy |
| PHC | Primary Health Care |
| TBA | Traditional Birth Attendant |
| TT2 | 2 Doses of Tetanus Toxoid Vaccine |
| U5MR | Under-five Mortality Rate |
| UCI | Universal Child Immunization |
| UNCTAD | United Nations Conference on Trade and Development |
| UNDP | United Nations Development Programme |
| UNEP | United Nations Environment Programme |
| UNESCO | United Nations Educational, Scientific and Cultural Organization |
| UNFPA | United Nations Population Fund |
| UNHCR | Office of the United Nations High Commissioner for Refugees |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |

BLANK

PAGE

## CHILDREN IN THE TOTAL POPULATION, 1988 (In millions)

| | Total | Under 16 | Under 5 |
|---|---|---|---|
| **WORLD** | **5093.1** | **1764.3** | **606.2** |
| **LATIN AMERICA & CARIBBEAN** | **423.7** | **164.7** | **56.1** |
| Argentina | 31.5 | 10.1 | 3.2 |
| Bolivia | 6.9 | 3.2 | 1.2 |
| Brazil | 144.4 | 54.6 | 18.7 |
| Chile | 12.7 | 4.2 | 1.4 |
| Colombia | 30.6 | 11.8 | 4.1 |
| Costa Rica | 2.9 | 1.1 | 0.4 |
| Cuba | 10.2 | 2.5 | 0.8 |
| Dominican Rep. | 6.9 | 2.8 | 1.0 |
| Ecuador | 10.2 | 4.4 | 1.6 |
| El Salvador | 5.0 | 2.4 | 0.8 |
| Guatemala | 8.7 | 4.2 | 1.5 |
| Guyana | 1.0 | 0.4 | 0.1 |
| Haiti | 6.3 | 2.6 | 0.9 |
| Honduras | 4.8 | 2.3 | 0.8 |
| Jamaica | 2.4 | 0.9 | 0.3 |
| Mexico | 84.9 | 34.9 | 11.4 |
| Nicaragua | 3.6 | 1.8 | 0.7 |
| Panama | 2.3 | 0.9 | 0.3 |
| Paraguay | 4.0 | 1.7 | 0.6 |
| Peru | 21.3 | 8.9 | 3.2 |
| Trinidad & Tobago | 1.2 | 0.4 | 0.1 |
| Uruguay | 3.1 | 0.9 | 0.3 |
| Venezuela | 18.8 | 7.7 | 2.7 |
| **MIDDLE EAST & NORTH AFRICA** | **281.5** | **123.9** | **45.7** |
| Algeria | 23.8 | 11.3 | 4.1 |
| Egypt | 51.5 | 22.1 | 8.1 |
| Iran, Islamic Rep. | 53.1 | 24.2 | 9.5 |
| Iraq | 17.7 | 8.7 | 3.2 |
| Jordan | 3.9 | 2.0 | 0.8 |
| Kuwait | 1.9 | 0.8 | 0.3 |
| Lebanon | 2.8 | 1.1 | 0.4 |
| Libyan Arab Jamahiriya | 4.2 | 2.0 | 0.8 |
| Morocco | 23.9 | 10.4 | 3.7 |
| Oman | 1.4 | 0.7 | 0.3 |
| Saudi Arabia | 13.1 | 6.2 | 2.4 |
| Syria | 11.6 | 5.9 | 2.2 |
| Tunisia | 7.8 | 3.2 | 1.1 |
| Turkey | 53.5 | 19.9 | 6.8 |
| United Arab Emirates | 1.5 | 0.5 | 0.2 |
| Yemen | 7.5 | 3.8 | 1.4 |
| Yemen, Dem. | 2.3 | 1.1 | 0.4 |
| **AFRICA SOUTH OF THE SAHARA** | **493.3** | **237.9** | **92.3** |
| Angola | 9.5 | 4.5 | 1.7 |
| Benin | 4.4 | 2.1 | 0.9 |
| Botswana | 1.2 | 0.6 | 0.2 |
| Burkina Faso | 8.5 | 3.9 | 1.5 |
| Burundi | 5.1 | 2.4 | 0.7 |
| Cameroon | 10.7 | 4.9 | 1.8 |
| Central. African Rep. | 2.8 | 1.3 | 0.5 |
| Chad | 5.4 | 2.4 | 0.9 |
| Congo | 1.9 | 0.9 | 0.3 |
| Côte d'Ivoire | 11.6 | 6.0 | 2.4 |
| Ethiopia | 44.7 | 21.5 | 7.6 |
| Gabon | 1.1 | 0.4 | 0.1 |
| Ghana | 14.1 | 6.7 | 2.6 |
| Guinea | 6.5 | 3.0 | 1.2 |
| Kenya | 23.1 | 12.5 | 5.1 |
| Lesotho | 1.7 | 0.8 | 0.3 |
| Liberia | 2.4 | 1.1 | 0.4 |
| Madagascar | 11.2 | 5.3 | 2.0 |
| Malawi | 7.9 | 3.8 | 1.5 |
| Mali | 8.8 | 4.3 | 1.7 |
| Mauritania | 1.9 | 0.9 | 0.3 |
| Mauritius | 1.1 | 0.3 | 0.1 |
| Mozambique | 14.8 | 6.8 | 2.6 |
| Namibia | 1.8 | 0.8 | 0.3 |
| Niger | 6.7 | 3.3 | 1.3 |

## CHILDREN IN THE TOTAL POPULATION, 1988 (in millions)

| | Total | Under 16 | Under 5 |
|---|---|---|---|
| **AFRICA SOUTH OF THE SAHARA (continued)** | | | |
| Nigeria | 105.5 | 53.4 | 21.8 |
| Rwanda | 6.8 | 3.5 | 1.4 |
| Senegal | 7.0 | 3.2 | 1.3 |
| Sierra Leone | 3.9 | 1.8 | 0.7 |
| Somalia | 7.1 | 3.5 | 1.4 |
| South Africa | 33.7 | 13.3 | 4.7 |
| Sudan | 23.8 | 11.3 | 4.3 |
| Tanzania | 25.4 | 12.5 | 5.2 |
| Togo | 3.2 | 1.5 | 0.6 |
| Uganda | 17.2 | 8.7 | 3.4 |
| Zaire | 33.8 | 16.3 | 6.3 |
| Zambia | 7.9 | 4.0 | 1.6 |
| Zimbabwe | 9.1 | 4.4 | 1.6 |
| **ASIA** | **2698.7** | **960.5** | **325.9** |
| Afghanistan | 15.1 | 6.7 | 2.6 |
| Bangladesh | 109.6 | 51.6 | 18.5 |
| Bhutan | 1.5 | 0.6 | 0.2 |
| China | 1104.0 | 324.9 | 102.0 |
| Hong Kong | 5.7 | 1.4 | 0.4 |
| India | 818.8 | 319.3 | 112.4 |
| Indonesia | 175.0 | 67.9 | 21.4 |
| Kampuchea | 7.9 | 2.8 | 1.4 |
| Korea, Dem. | 21.9 | 8.7 | 3.0 |
| Korea, Rep. | 42.6 | 8.7 | 3.0 |
| Laos | 3.8 | 1.7 | 0.7 |
| Malaysia | 16.6 | 6.4 | 2.3 |
| Mongolia | 2.1 | 0.9 | 0.3 |
| Myanmar | 40.0 | 16.1 | 5.5 |
| Nepal | 18.2 | 8.1 | 3.0 |
| Pakistan | 114.9 | 54.3 | 22.3 |
| Papua New Guinea | 3.8 | 1.7 | 0.6 |
| Philippines | 59.5 | 25.4 | 9.0 |
| Singapore | 2.6 | 0.7 | 0.2 |
| Sri Lanka | 16.8 | 5.9 | 1.9 |
| Thailand | 54.1 | 19.7 | 6.0 |
| Viet Nam | 64.2 | 27.0 | 9.2 |
| **INDUSTRIAL COUNTRIES** | **1195.9** | **277.3** | **86.2** |
| Albania | 3.1 | 1.1 | 0.4 |
| Australia | 16.4 | 4.0 | 1.2 |
| Austria | 7.5 | 1.4 | 0.4 |
| Belgium | 9.9 | 2.0 | 0.6 |
| Bulgaria | 9.0 | 2.0 | 0.6 |
| Canada | 26.1 | 5.9 | 1.9 |
| Czechoslovakia | 15.6 | 4.0 | 1.1 |
| Denmark | 5.1 | 1.0 | 0.3 |
| Finland | 5.0 | 1.0 | 0.3 |
| France | 55.8 | 12.3 | 3.8 |
| Germany, Dem. | 16.6 | 3.5 | 1.1 |
| Germany, Fed. | 60.7 | 9.8 | 3.1 |
| Greece | 10.0 | 2.2 | 0.6 |
| Hungary | 10.6 | 2.3 | 0.6 |
| Ireland | 3.7 | 1.1 | 0.3 |
| Israel | 4.4 | 1.5 | 0.5 |
| Italy | 57.3 | 11.2 | 3.0 |
| Japan | 122.4 | 26.0 | 7.0 |
| Netherlands | 14.6 | 2.9 | 0.9 |
| New Zealand | 3.3 | 0.8 | 0.3 |
| Norway | 4.2 | 0.9 | 0.3 |
| Poland | 38.0 | 10.3 | 3.2 |
| Portugal | 10.2 | 2.4 | 0.7 |
| Romania | 23.0 | 5.9 | 1.7 |
| Spain | 39.1 | 9.0 | 2.5 |
| Sweden | 8.3 | 1.5 | 0.4 |
| Switzerland | 6.5 | 1.2 | 0.4 |
| United Kingdom | 56.8 | 11.5 | 3.7 |
| USA | 245.4 | 56.3 | 18.3 |
| USSR | 283.7 | 76.4 | 25.2 |
| Yugoslavia | 23.6 | 5.9 | 1.8 |

Source: The State of the World's Children 1990, Tables 1 and 5.
(For explanations and qualifications of specific figures, see notes there.)
Figures for country groupings are totals (exclusive of countries with population under one million).

BLANK

PAGE

## PART ONE:

# *Overview*

*Introduction*

*This* Sourcebook on Children and Development in the 1990s *has been compiled on the occasion of the World Summit for Children, but it is intended to be of use well beyond that momentous event. It is meant for all those who wish to extend their knowledge of any of the themes under discussion at, or around, the Summit, stating the issues and providing readers with the background information, explanations, definitions, data, and references they may require to obtain a deeper understanding of the subjects.*

*The background material provided here will also assist in the initial implementation of the world's agenda for children in the 1990s to the extent that Summit participants include each theme treated here in that agenda. As none of these themes is static, this book is compiled in such a way that its individual sections can be updated from time to time with new data and new text, reflecting progress in achievement and understanding.*

*This book is organized around a set of goals for children in the 1990s. These goals are not intended to pre-empt the Summit's decisions. They are the goals that were approved by the UNICEF Executive Board in April 1990, and the majority of them are joint goals shared with one or more other world bodies, such as WHO, UNESCO, UNFPA, and the World Bank.*

*The agenda for children that these goals, taken together, constitute is very ambitious. Despite the obstacles, UNICEF views the agenda as feasible, provided the political will exists to implement it. UNICEF hopes the leaders of the world who are assembled for the Summit will take a similar view and support the agenda for children in the 1990s with the weight of their power and influence.*

*Goals, once properly adapted to country realities, can serve as powerful rallying points for national action and international solidarity. They can help shift the focus from excessive preoccupation with constraints to exploration of opportunities. By gaining popular understanding and credibility, easily understood human goals may contribute more to real development than all the voluminous development plans of governments and international agencies. Specific, doable goals are more amenable to advocacy at senior levels of government and among other power elites than are generalized*

*development issues. Human goals with the power to inspire can be effective instruments for mobilizing support from groups that would otherwise not be excited about general development programmes. The pursuit of common goals, albeit with different means and modalities, can provide a useful focus for inter-agency collaboration. Finally, goals can be powerful instruments for tightening management and accountability.*

*Goals are attainable only in the concrete circumstances of particular countries, communities, and families. Global goals, however, provide a yardstick for aspirations that are shared among nations, and combinations of global goals serve to underline the interrelatedness and mutual reinforcement that the common pursuit of a coherent set of goals by many nations can provide.*

*Many problems transcend national boundaries. For example, efforts to eradicate, or even contain, malaria in a single country can be frustrated by the failure to contain it in other contiguous countries. Many other problems of the 1990s, such as drug abuse, AIDS, global warming, and other environmental issues will not be solved through strategies confined within one country's boundaries. National goals for dealing with these problems will require regional and global strategies, leading inevitably to global or at least regional goals.*

*Often, cumulative country experiences will lead to global goals. When a major country or group of countries succeeds in setting and achieving certain goals, other countries are inspired to set similar goals, often leading to adoption of regional and eventually global goals.*

*Also, global goals can spur certain national goals, the success of which depends on the achievement of the global goals. For instance, the eradication of smallpox could not have been achieved in the relatively short time span of the 1960s and 1970s if it had been left entirely to the discretion of national authorities without a global push. Similarly, such goals as the eradication of polio, elimination of dracunculiasis, and control of iodine deficiency disorders in the 1990s will require major world-wide efforts.*

*For all of these reasons, this book is organized mainly around goals, though it also discusses certain essential concerns like "the girl child" and "the urban child" that cut across sectors and are less susceptible to formulation in terms of single objectives. There is also a section on economic support and sustainability. It deals with some of the economic conditions necessary to make the social goals for children feasible.*

*UNICEF hopes this compendium will serve all who are engaged in making the World Summit for Children a success. May it be of even greater value to those who will translate the Summit Declarations into concrete follow-up actions for the benefit of the world's children.*

# *The principle of first call for children and the Convention on the Rights of the Child*

## In brief

**The principle of first call for children complements the historic Convention on the Rights of the Child that seeks to ensure that children under 18 years of age develop to their full potential free from hunger, want, neglect, exploitation, and other abuses. This chapter examines some of the specific rights that the Convention sets forth and some of the responsibilities nations and families have to ensure those rights. By giving children and their needs the highest possible priority and by translating the rights enshrined in the Convention into laws, plans of action, and allocation of resources, the achievement of the decade goals for children will receive an enormous impetus.**

In both industrialized and developing countries, there is a growing recognition that the physical, mental, and emotional needs of the young are legitimate matters of concern for a nation's political leaders. President Bush of the United States, for example, has expressed the belief that "our national character can be measured by how we care for our children." And in making the same point about the world's responsibility for its children, President Gorbachev of the Soviet Union has stated that at the close of the twentieth century "mankind can no longer put up with the fact that millions of children die every year."

Underlying the many decisions and actions that must be taken if the needs of children are to be dealt with seriously is the principle of *first call for children.* This principle is that the essential needs of children should be given high priority in the allocation of resources in bad times as well as in good, at the national and international levels, as well as at the family level.

At the family level, the principle of first call gives the growth of a child's body and mind the priority attention it deserves, in terms of food and nutrition, education, child care, shelter, and other needs. At the national and international levels, the principle awards high priority to protection of children in times of financial austerity, natural calamities, and wars and conflicts, as well as in times of progress and prosperity.

Acceptance of this principle would add an important dimension to national development planning and international co-operation, making the well-being of children an explicit criterion in assessing and evaluating development programmes. For example, programmes for structural adjustment and debt relief would be assessed not only in terms of their macro-economic merits, but also in terms of their impact on children and human development.

This principle of first call is especially pertinent to the present moment in history when the Cold War is ending and debate over the reallocation of resources previously devoted to armaments is engaged. If children were considered first, the discussion would automatically turn to considerations of the environment, sustainable human development, resolution of the debt crisis, education, health, water supply, and nutrition – in short, all that society should be thinking of as it adjusts to an era of peace.

## The Convention on the Rights of the Child

The principle of first call for children is embodied in the Convention on the Rights of the Child, a document covering civil, economic, social, cultural, and political rights for children. The United Nations General Assembly adopted the Convention by consensus on November 20, 1989, and its ratification by Member States is well underway.

The Convention has been variously described as a 'Magna Carta' or 'Bill of Rights' for children. It has 54 articles detailing the individual rights of any person under 18 years of age to develop to his or her full potential, free from hunger, want, neglect, exploitation, and other abuses.

By adopting the Convention, the General Assembly, after 10 years of often intricate negotiation, recognized that children have needs and human rights that extend far beyond basic concepts of protection.

## Ratification and implementation

When the Convention was opened for signing on 26 January 1990, 61 countries signed it—an unprecedented first day response and a big first step by each country towards ratification. At the time this report was compiled, 92 countries had signed the Convention and twenty two countries had ratified it. By the time this report is published the Convention will have entered into force.

The Convention now enters into force as international law for those countries which have ratified it, the States Parties to the Convention.

To be a truly global treaty, the Convention needs ratification by countries from all regions. These countries, by ratifying the Convention, declare themselves willing to be fully bound by the Convention's provisions and answerable to the international community if they fail to comply. A Committee of 10 experts will monitor compliance with the Convention.

These compliance officers will be elected at a meeting of the States Parties to the Convention, six months after the Convention enters into force.

Standards set by the Convention

The Convention on the Rights of the Child addresses the neglect and abuse children suffer in every country, to varying degrees, every day. It recognizes a child's special vulnerability and treats a child's civil, political, economic, social, and cultural rights as elements of an interdependent or mutually reinforcing package. The Convention breaks new ground with this holistic approach, acknowledging that although a child may be adequately nourished (a social right), the child's right to develop fully is not adequately protected unless the child is also educated (a social and cultural right), allowed to participate in culture and religion (a cultural right), and shielded from such things as arbitrary detention (a civil right) and exploitation at work (a social and economic right).

The Convention also recognizes a child as an individual with needs that evolve with age and maturity. Accordingly, it goes beyond existing treaties by seeking to balance the rights of the child with the rights and duties of parents and others responsible for a child's survival, development, and protection, by giving the child the right to participate in decisions affecting both the present and the future.

Survival, development, protection, and participation

Under the Convention, *survival rights* include such things as adequate living standards and access to health and medical services. *Development rights* include education; access to information, play and leisure; cultural activities; and the right to freedom of thought, conscience, and religion. *Protection* embraces all of the above, but also covers all forms of exploitation and cruelty, arbitrary separation from family, and abuses in the criminal justice system. *Participation rights* include the freedom to express opinions and to have influence in matters affecting one's own life, as well as the right to play an active role in society at large. The main underlying principle of the Convention is that the best interests of the child shall always be a major consideration. It states clearly that the child's opinion shall be given due regard.

Other pressing issues, some of which are specifically addressed for the first time in an international convention, include obligations to children in special circumstances, such as the needs of refugee children (article 22); protection from sexual and other forms of child exploitation (articles 34 and 36); drug abuse (article 33); children in trouble with the law (article 40), inter-country adoptions (article 35); children in armed conflicts (articles 38 and 39); the needs of disabled children (article 23), and the needs of children of minority and indigenous groups (article 30).

Under the Convention, children are entitled to the highest attainable

health standards and access to facilities for the treatment of illness and rehabilitation. Where governments are economically incapable of providing such services, international co-operation to ensure this right is emphasized (article 24).

Parents have the primary responsibility for standards of living that guarantee their children's physical, mental, spiritual, moral, and social development, but States Parties to the Convention are expected to provide support programmes where necessary, particularly in the areas of nutrition, clothing, and housing (article 27).

Education is the subject of two major articles (27 and 28), which were reinforced by the World Conference on Education for All in Thailand (5-9 March 1990). Primary education should be compulsory, free to all, and directed toward the development of a child's personality, talents, and natural abilities, with due respect for cultural identity, language, and values. Stress is placed on equality of educational opportunity for girls and boys.

When a child is capable of forming his or her own views, those opinions are to be given due weight in accordance with the child's age and maturity, a provision with particular significance in judicial and administrative proceedings directly affecting the child (article 12).

States Parties to the Convention are expected to establish a minimum age for work, as well as regulations governing hours and conditions of employment (article 32). They are also obliged to take national, bilateral, and multilateral measures to protect children against all forms of sexual exploitation (article 34).

## The universal approach

The Convention carefully allows for the different cultural, political, and economic realities of individual States. In doing so, it complements the Declaration on the Rights of the Child, which maintains that "mankind owes to the child the best it has to give." This approach gives the Convention latitude to encourage assistance to nations lacking the resources to adequately care for their children, while also addressing the serious child welfare problems often found in rich countries.

In the early drafting stages of the Convention, some questioned whether it was feasible to define universal rights for children, given the diversity among nations of socio-economic, religious, and cultural perceptions of childhood and the child's role in the family and society at large. But those who drafted the Convention take the view that although methods of upbringing, socialization, and opportunity vary greatly from one country to another, concern for the protection of a broad range of children's rights is shared by all peoples. Experience suggests that the reactions of all communities and nations are essentially the same when children are subjected to torture, separated from their families, deprived of food or proper medical care, or maimed in armed conflicts. The Convention,

therefore, represents a consensus that, while the means of achieving child rights may differ and be given different priorities from one country or situation to another, there are universally accepted pre-conditions for any child's harmonious and full development.

Flexibility

The inherent strength of the new Convention is its flexibility to accommodate the many different approaches of nations in pursuit of a common goal. It has not evaded sensitive issues, but has found means to adjust to the different cultural, religious, and other values that address universal child needs in their own ways. This was a ground-breaking experience for international lawmakers, who developed the approach over a 10-year drafting period following the International Year of the Child in 1979. While setting an upper age limit for childhood at 18 years, the Convention allows for exceptions in countries where the age of majority is set lower. It does not specify how parents should bring up their children, but stipulates that children have the right to receive care and protection from their families and the state, and it also defines the areas in which that care and protection should be provided.

**The principle of first call for children is that the essential needs of children should be given high priority in the allocation of resources in bad times as well as good, at the national and international levels, as well as at the family level.**

In the sensitive cases of child adoption and alternative family care, a way was found to provide protection, while allowing all parties to accept the Convention as a whole. In some cases adoption has lent itself to cruel abuses, including child trafficking and slavery. Accordingly, under the Convention, states shall provide parentless children with suitable alternative care. The adoption process shall be carefully regulated, and international agreements shall be sought to provide safeguards and assure legal validity if and when adoptive parents intend to move a child from his or her country of birth.

A role for all in realizing the ideas of the Convention

Parliamentarians, educators, religious leaders, the media, and non-governmental groups have made efforts to ensure that the Convention gives the highest priority to the national planning and legislation that will strengthen the articles of the Convention with practical force. The Convention provides benchmarks for achievements and a universally acceptable basis for advocacy that will be pursued by international agencies and non-governmental organizations on behalf of children everywhere.

Nations that ratify the Convention will be obliged to see that the rights contained in it are widely known, and to report regularly on their efforts to honour them. They will report directly to the Committee on the Rights of the Child, and international organizations such as UNICEF, ILO, and UNESCO are likely to be present when the Committee considers each report. UNICEF, other UN bodies, and non-governmental specialist agencies have indicated their readiness to provide technical advice and other assistance on request.

Responsibility for the rights of children will ultimately hinge on the translation of agreed principles into national laws, plans of action, and allocation of resources. What the Convention has done is to stake a claim for children at the top of national and international agendas, while placing the responsibility for meeting the needs of children in the hands of the family in the first instance, followed by governments and society at large.

Further reading

*Convention on the Rights of the Child.* Resolution adopted by the United Nations General Assembly at its forty-forth session. A/RES/44/25. 5 December 1989.

*Human Rights Quarterly*, Volume 12, Number 1, February 1990, pp. 94-175 (contains nine articles that form a Symposium on the Convention).

# *Goals for children and development in the 1990s*

## In brief

**This chapter sets out the decade goals for children that UNICEF and many others consider achievable by the year 2000, if world leaders put the weight of their prestige behind them and commit themselves to achieving them. The adaptation of these goals to different country situations is also discussed.**

The Convention on the Rights of the Child sets an agenda for children, the full implementation of which will require decades of work. Within the comprehensive framework provided by the Convention, specific goals in areas such as health, nutrition, and education, have been formulated by various global assemblies. The goals on which this compendium is based are those adopted by the UNICEF Executive Board in April 1990, but most of them were formulated jointly with other agencies during a two-year-long process that began in March of 1988.

Many of these goals were initially formulated as part of "Protecting the world's children: an agenda for the 1990s," which was introduced as the "Talloires Declaration" in March 1988 by the Task Force for Child Survival. The Task Force, composed of the World Bank, UNDP, WHO, UNICEF, and the Rockefeller Foundation, periodically brings together health ministers and senior officials from developing countries and leaders of major bilateral and other multilateral aid organizations. The Talloires Declaration is the basis for the initial list of WHO/UNICEF common goals for the health development of women and children by the year 2000 that was endorsed in 1989 by the UNICEF/WHO Joint Committee on Health Policy and by the Executive Boards of both UNICEF and WHO.

The goals approved by the UNICEF Executive Board in 1990 draw upon the WHO/UNICEF common goals, including modification recommended at the March 1990 meeting of the Child Survival Task Force in the "Bangkok Affirmation," and also include goals outside the health sector, such as those dealing with child rights, protection of children in especially difficult

circumstances and goals in the areas of education, literacy, and early child development, as endorsed by the World Conference on Education for All held in Jomtien, Thailand, in March 1990.

*Since the needs of children cut across many sectors, the list of goals* contained in UNICEF documents is broader than the specific sectoral goals of United Nations agencies such as WHO, UNESCO, and UNFPA. Footnotes to this list indicate which of the goals are held in common by the relevant United Nations organizations.

Goals for children and development in the 1990s

**A. Major goals for child survival, development and protection[1]**

(1) Between 1990 and the year 2000, reduction of the infant mortality rate (IMR) and the under-five mortality rate (U5MR) in all countries by one third, or to 50 and 70 per 1,000 live births, respectively, whichever is less.[2]

(2) Between 1990 and the year 2000, reduction of the maternal mortality rate (MMR) by one half. [2]

(3) Between 1990 and the year 2000, reduction of severe and moderate malnutrition among children under five years of age by one half.[3]

(4) Universal access to safe drinking water and to sanitary means of excreta disposal.[3]

(5) By the year 2000, universal access to basic education and achievement of primary education by at least 80 per cent of primary school-age children.[4]

(6) Reduction of the adult illiteracy rate (the appropriate age-group to be determined in each country) to at least one half of its 1990 level, with an emphasis on female literacy.[4]

(7) Improved protection of children in especially difficult circumstances.

**B. Supporting/sectoral goals**

**Women's health and education**

(8) Special attention to the health and nutrition of female children and pregnant and lactating women.[3]

(9) Access by all couples to information and services to prevent pregnancies that are too early, too closely spaced, too late, or too many.[2]

(10) Access by all pregnant women to pre-natal care, trained attendants during childbirth, and referral facilities for high-risk pregnancies and obstetric emergencies.[2]

(11) Universal access to primary education, with a special emphasis on girls, and accelerated literacy programmes for women.[2]

### Nutrition

(12) Reduction in severe and moderate malnutrition among children under five years of age by one half of 1990 levels.[3]

(13) Reduction of the rate of low birth weight (less than 2.5 kilograms) to less than 10 per cent.[3]

(14) Reduction of iron deficiency anaemia in women by one third of 1990 levels.[3]

(15) Virtual elimination of iodine deficiency disorders (IDD).[3]

(16) Virtual elimination of vitamin A deficiency and its consequences, including blindness.[3]

(17) Empowerment of all women exclusively to breastfeed their child for four to six months and to continue breastfeeding, with complementary food, well into the second year.[2]

(18) Growth promotion and its regular monitoring to be institutionalized in all countries by the end of the 1990s.

(19) Dissemination of knowledge and supporting services to increase food production to ensure household food security.

### Child health

(20) Global eradication of poliomyelitis by the year 2000.[3]

(21) Elimination of neonatal tetanus by 1995.[3]

(22) Reduction by 95 per cent in measles deaths and reduction by 90 per cent of measles cases by 1995 compared with pre-immunization levels as a major step towards the global eradication of measles in the longer run.[3]

(23) Maintenance of a high level of immunization coverage (at least 90 per cent of children under one year of age) against diphtheria, pertussis, tetanus, measles, poliomyelitis, and tuberculosis and against tetanus for women of child-bearing age.

(24) Reduction by 50 per cent in the deaths caused by diarrhoea in children under the age of five years and 25 per cent reduction in the diarrhoea incidence rate.[3]

(25) Reduction by one third in the deaths caused by acute respiratory infections (ARI) in children under five years of age.[3]

### Water and sanitation

(26) Universal access to safe drinking water.[3]

(27) Universal access to sanitary means of excreta disposal.[3]

(28) Elimination of Guinea worm disease (dracunculiasis) by the year 2000.[3]

### Basic education

(29) Expansion of early childhood development activities, including

appropriate low-cost family and community-based interventions.[4]

(30) Universal access to basic education and achievement of primary education by at least 80 per cent of primary school-age children through formal schooling or non-formal education of comparable learning standard, with an emphasis on reducing the current disparities between boys and girls.[4]

(31) Reduction of the adult illiteracy rate (the appropriate age-group to be determined in each country) to at least one half of its 1990 level, with an emphasis on female literacy.[4]

(32) Increased acquisition by individuals and families of the knowledge, skills, and values required for better living made available through all educational channels, including the mass media, other forms of modern and traditional communication, and social action, with effectiveness measured in terms of behavioural change.[4]

**Children in especially difficult circumstances**

(33) Provide improved protection of children in especially difficult circumstances and tackle the root causes leading to such situations.

Adaption of goals to different country situations

The global goals mentioned above should be considered on a country-by-country basis and translated into national goals with their own target dates, standards, and additional country-specific objectives. Such country-specific adaptation of global goals is crucial, not only to ensure technical and logistical feasibility, but also to secure the financial backing and political support necessary for the realization of these goals. Consultations with governments, relevant NGOs, the media, and other social organizations during formulation of country goals will greatly enhance the chances of mobilizing these groups for the implementation of the goals.

Standards for adapting these goals may vary from country to country. For instance, in the higher-income developing countries, universal access to safe drinking water might mean having water indoors or in the yard of every house; in lower-middle-income countries, it might mean having water available within no more than 500 metres from most households; and in some Least Developed Countries, it might mean having water available within one kilometre. Similarly, targets for adult literacy might be set in terms of 15 to 55 years in higher-income countries, whereas one might restrict the age group to 15 to 45 years in the case of lower-income countries.

It is recognized that the Least Developed Countries will not be able to attain most of the goals for the 1990s without extroadinary effort, internal

political commitment, and external support. For some of the high-income developing countries and industrialized countries, on the other hand, many of the goals might not be challenging enough. Therefore, some adaptation of goals to suit the varying typology of countries is essential.

Because of the variation of standards for the same goals, considerable variation in strategies will be needed to reach these goals. Strategies, however, constitute an entire theme in itself, one which will be discussed in the following chapter.

## Notes

1/ Most of the major goals for the reduction of IMR/U5MR, access to water and sanitation, education and literacy, etc., were included in the goals for the Third United Nations Development Decade and are being updated for inclusion in the international development strategy for the Fourth United Nations Development Decade.

2/ Joint UNICEF/WHO/UNFPA goal.

3/ Joint UNICEF/WHO goal. This goal has also been endorsed by the International Task Force for Child Survival composed of WHO, UNICEF, UNDP, the World Bank, and the Rockefeller Foundation.

4/ Joint UNICEF/UNESCO goal. This goal was endorsed by the World Conference on Education for All and represents a common goal of the four sponsoring agencies of the conference (UNESCO, UNDP, the World Bank, and UNICEF) and the many co-sponsoring agencies.

BLANK

PAGE

# *Strategies for achieving the goals*

## In brief

**Although each country's circumstances will determine the way the goals for children are set and reached, a number of broad concerns will shape specific strategies. This chapter sets out these broad concerns, including the need for area-based, multisectoral services to be provided to the poorest and most vulnerable; the need to reduce disparities between and within sections of populations; and the need for women to be empowered through education and training. Major achievements in child survival and development in the 1980s–such as accelerated immunization coverage and improved literacy programmes–resulted from unprecedented social mobilization, involving a wide spectrum of social forces, backed by the vision and will of political leaders. These impressive successes against extraordinary odds show that the right combination of technical interventions and social mobilization, supported by political will, can improve the ratio of results to resources and achieve development with a human or a child's face.**

The goals for the year 2000 enumerated in the previous chapter are admittedly very ambitious in the light of past experience and current trends. While they are considered technically feasible and financially affordable, to achieve them will require strategic actions that speed the pace of progress beyond historical trends.

A strategy is a coherent set of policies, programmes, and projects, which defines the path to be pursued towards the achievement of a set of goals. A strategy provides the framework for plans and reconciles the trade-offs required when scarce resources are devoted to the pursuit of multiple goals. Such a set of policies, programmes, and projects must be devised and implemented at the particular development level of each country. And in most countries the national strategy must be complemented by regional and local strategies as well.

The appropriate means for reaching the goals depends on the particular circumstances of each country. For example, to reach the infant mortality and under-five mortality goals, it is important to identify disease patterns of the major fatal diseases in the region. These may be diarrhoeal diseases in one country, malaria in another, vaccine preventable diseases in some countries, acute respiratory infections (ARI) or the spreading scourge of AIDS in other countries, or perhaps a combination of all or some of these.

Similarly, to reach basic education for all, the emphasis would be on formal primary education in most countries, but in many countries non-formal education may also constitute a major element of the package, or there may be special emphasis on early child stimulation at the pre-primary level, which has been proven to enhance the quality and efficiency of primary education.

Strategies will vary from country to country and sector to sector. However, the following are likely to be the essential strategic elements common to most countries and sectors.

## Going to scale

The experience of the 1980s has demonstrated that many programmes related to the human goals for the 1990s lend themselves to mass application at national levels. So, it is no longer as necessary as in earlier decades to devote an inordinate amount of time and energy to small scale pilot projects, some of which are difficult to replicate on a larger scale. The challenge of the 1990s is to disseminate what has already been learned from pilot projects on a scale that can lead to universal coverage of most of the basic services for human development.

There is always room for innovation and refinement of strategies already known to work. However, while work on such innovation and refinement deserves support and attention, priority should be given to large-scale implementation of services that have proven to work.

## Reaching the unreached and hard to reach

As the coverage of services reaches the majority, it becomes increasingly difficult to reach the last 15 to 20 per cent of the population that is concentrated in remote, inaccessible areas or in overcrowded urban shanty towns. These people are often the poorest of the poor and the most vulnerable. The difficulty of reaching them and the sometimes relatively high cost of providing services to them has often deterred and discouraged development workers. Nevertheless, in any scheme of development that puts human well-being at the centre of development strategy, a high priority should be assigned to reaching the unreached and hard to reach .

Just as helping the least developed and landlocked countries should receive special attention from the international community, reaching the

poorest communities should be a priority of national development. After all, the problems of malnutrition, ill health, child deaths, maternal mortality, illiteracy, and low productivity are concentrated among the poorest 25 per cent of the families. It is therefore not enough to state global goals only in terms of national averages. As part of reaching the national goals, some sub-national goals should be specified so as not to leave out any sizeable administrative unit or ethnic, racial, or gender group. The uplifting of such under-privileged sub-national target groups should command a significant share of the investment available for development. In fact, universalization is a way of assuring that the poorest are reached, provided that the target for defining universal coverage is set high enough.

Disparity reduction

Disparity reduction is a major strategic principle that is universally applicable and often more relevant and meaningful than reaching particular numerical targets. It identifies people who are falling below the mean and targets programmes to move these people into the mainstream. It helps monitor not only key indicators of progress, but also the gap between the haves and have-nots in the disaggregated population. Monitoring averages becomes less sensitive as service coverage expands. It is the reduction of disparities, rather than the absolute level of the indicator itself, that measures the effectiveness of development programmes in bringing about greater equity. It is, for instance, the analysis of disparities that has led countries in the South Asian Association for Regional Co-operation (SAARC) and the Middle East and North Africa (MENA) region to emphasize that UNICEF should champion affirmative action in favour of the girl child.

Advocacy and social mobilization

During the 1980s, none of the major achievements in child survival and development, such as the immense acceleration in immunization coverage, oral rehydration therapy (ORT), family planning services, or literacy programmes, could have been accomplished solely by the sectoral government departments concerned.

It has taken the mobilization of many organizations–many of them previously totally unconcerned with or uninvolved in child-related issues–to bring these developments to the doorstep of the masses. The active participation of political leaders at different levels, non-governmental organizations (NGOs), school systems, religious leaders, artists and intellectuals, labour unions and peasant cooperatives, women's and youth movements, and neighbourhood associations was mobilized using the communications channels offered by newspapers, radios, television, and

personal contacts that made it possible to reach families that had never been reached by conventional government services. Such social mobilization on a massive scale is crucial not only for alternative delivery channels for essential services, but even more importantly for creating awareness of and the demand for such services.

Creation of popular awareness of, demand for, and participation in programmes of human development will create its own momentum for the rapid fulfillment of the human goals for the 1990s. In developing countries politicians will have to respond to an assertive constituency; scientists and technologists will be persuaded to orient their research to meeting human needs; and in the industrialized countries public support will be generated for development co-operation. Such social mobilization and creation of alliances and partnerships for children and human development are essential to reach the goals of child survival and development in the 1990s.

During the 1980s, there was unprecedented involvement among the highest levels of political leaders in child survival and development actions. Many Heads of State or Government and parliamentarians in all continents personally participated in national vaccination campaigns. Heads of State and Government made collective declarations of their commitment to child survival and development at Summit meetings of the Organization of African Unity (OAU), the SAARC, the Commonwealth and Francophone nations, the non-aligned countries, and even at the Summit meeting between the United States of America and the Union of Soviet Socialist Republics in Moscow in 1988. The World Summit for Children will undoubtedly be a milestone for putting and keeping the needs of children high on the political agenda throughout the 1990s.

The world has a new capacity for delivering to every family knowledge for dramatically improving the well-being of children through radio and television, VCRs, popular theatre, and community organizations. A major effort should be undertaken to form alliances with activists who can galvanize this cumulative outreach to spread the knowledge and skills that can empower parents to improve the quality of life of their children.

## Community participation

If goal achievements are to become self-sustaining there must be active, willing, and informed participation of communities. All development programmes – including those for child survival, protection, and development – must be responsive to people's needs, and must empower people to analyse and solve their own problems. Prescriptions based on the expertise and judgement of outsiders can be helpful, but communities' genuine ownership of programmes based on awareness and popular demand is a *sine qua non* for long-term success of all development programmes.

**Area-based programme approaches**

Area-based programming approaches, whether for integrated rural development or urban basic services, can serve as valuable testing grounds for community acceptance and sustainability of new programme interventions. Such programmes are also helpful in testing the appropriateness of sectoral goals in the context of multisectoral basic services approaches. As the felt needs of communities are multifaceted and synergistic rather than sectoral, the ideal development programmes are usually area-based basic services. To be successful and sustainable, even vertical programmes must be closely linked with and supportive of such multisectoral approaches.

Area-based programmes also offer the benefits of securing political commitment and leadership from the local administrative and political authorities.

**Research and development**

Further research and development in the major problem areas confronting the world's children would accelerate progress towards the goals for child survival, development, and protection. At present only 5 per cent of global expenditure on health research is devoted specifically to the health problems of developing countries. Investment is similarly inadequate in other research fields, such as education, agriculture, and energy, where results could improve the quality of life of the poor masses in developing countries .

The prospects for arms reduction and the lessening of international tensions may soon release some of the world's scientific talent from military research to more peaceful pursuits. Additional study in the field of international health research, both biomedical and social, could bring about dramatic improvements in providing better vaccines that are heat-stable and require fewer doses, and in the treatment and prevention of malaria, ARI, diarrhoeal diseases, and AIDS. The international community must greatly increase its support for research and development, and must encourage collaboration among institutions in both developing and industrialized countries in the study of major problem areas affecting the well-being of the most underprivileged children and families in the world.

**Empowerment of women for development**

In the past decade the primacy of women in much of the development process has been acknowledged and supported in various international fora and declarations. It is well known that the women of the developing world are responsible for producing and marketing most of its food crops. They also carry the main responsibility for food preparation and home-making, for water and fuel, for nutrition and health care, for hygiene, and for the education of the young. Women are the *de facto* heads of household in many families, particularly in situations characterized by migration, e.g.

from the rural to urban areas, or when families are displaced by armed conflict or natural calamity. And more women are taking up employment in the modern sector of the economy. Yet, in far too many development programmes, most of the education and training, technology and inputs, credits and investment are aimed at men–not women. To bridge this gap between the recognized role of women in development and their actual neglect, it is essential that women receive equal access–sometimes even preferential access–to education, training, credit, and other extension services. In particular, investment in female education, safe motherhood, income-generating activities, and labour-saving devices of particular relevance to women (such as more fuel efficient methods of cooking and less labour-intensive ways of preparing food and fetching water and fodder) are and should be regarded as among the most productive investments in social and economic development. Empowering women for development should therefore be both a means and an end of development.

**The challenge of the 1990s is to disseminate what has already been learned from pilot projects on a scale that could lead to universal coverage of most of the basic services for human development.**

## Development with a human face

The need for "structural adjustment" of economies that are out of balance is now universally accepted. It is also increasingly recognized that too often the poorest segments of the population carry the heaviest burden of economic adjustment. Whereas in the early 1980s it was assumed that the negative repercussions of adjustment were unavoidable, recent studies (including some by UNICEF) have demonstrated that it is possible and highly desirable to design adjustment packages that seek to protect the poorest families and their children by improving the productivity and incomes of the poor, maintaining well-targeted food subsidies, and expanding primary health and basic education. This imposes tough choices on policy makers between services that are of concern to the richer and more powerful sections of society (the major city hospitals, universities, and national airlines) versus services that are of concern to the poorer and less powerful (immunization programmes, primary schools, and subsidies for public transport). The choice is not between adjustment or no adjustment, but between adjustment primarily aimed at balancing the budget and trade deficits, and adjustment that also seeks to protect the poor and the vulnerable and to enhance *their* productivity.

If the human and economic goals of the Fourth Development Decade are to be realized, the leaders of both industrial and developing countries will have to make even tougher choices as they pursue not just adjustment, but *development* policies with a human face in the 1990s. Unprecedented

opportunities for action lie in the resolution of regional conflicts, progress in arms reduction by the super powers, prospects for reduced military expenditures, growing universal concern with the degradation of the environment, and support for human rights, including children's rights.

Growing evidence of the widening gap between what is technically and financially feasible in terms of low-cost, high-impact solutions to the most pressing problems of children and what is actually being accomplished points to some obvious areas for further action in the 1990s. While material and financial resources continue to be limited, the ratio of results to resources can be vastly improved. Several examples of impressive achievements in child survival and development by countries facing extraordinary odds in the 1980s indicate that much can be achieved with the right combination of technical interventions and social mobilization, backed by the necessary political will and vision. The lessons of these experiences should be used in formulating development strategies with a human–or perhaps a child's–face, in the same way the painful experiences of structural adjustment in the early 1980s has led to the growing acceptance of adjustment policies with a human face.

### Environmental soundness and sustainability

A human environment characterized by high rates of morbidity, mortality, fertility, illiteracy, and ignorance is not conducive to sustainable development. The child survival and development goals proposed for the 1990s seek to improve this environment by combating disease and malnutrition and by promoting education. These contribute to lower birth rates and death rates, improved social services, better use of natural resources, and ultimately to the breakdown of the vicious cycle of poverty and environmental degradation.

Programmes to reach the human goals of the 1990s are highly compatible with and supportive of environmental protection because of their relatively low use of capital resources and high reliance on social mobilization, community participation, and appropriate technology. However, each programme needs to be tested against an explicit set of criteria for sustainability and environmental soundness. Children have the greatest stake in sustainable development as their survival, development, and protection depend on it. From their point of view, all development strategies must meet the needs of the present generation without compromising the ability of future generations to meet their own needs.

### Monitoring and evaluation

If human goals are to be central in measuring the performance of national and international development in the 1990s, data on changes in the infant mortality rate (IMR), the under-five mortality rate (U5MR), the maternal mortality rate (MMR), literacy rates, nutritional status, access to water and sanitation,

and other social indicators must be collected and updated much more frequently than every 5 or 10 years, as at present. The current system of data collection and feedback are clearly not responsive enough to rapid appraisal of progress and constraints. To ensure rapid course correction and remedial action, new and innovative ways of monitoring and evaluating the attainment of the human goals of the Fourth Development Decade need to be devised.

For more than 10 years now, the international development community has been expressing serious reservations about the primacy of the GNP as the principal measure of a country's level and pace of development. If during the 1990s human development is accorded the place of primacy, the international community, under the leadership of the United Nations, should take bold measures to help develop more universally acceptable social indicators of development, such as those recently proposed by UNDP in its *Human Development Report*. This report proposes a Human Development Index based on life expectancy, literacy, and purchasing-power-adjusted gross domestic product.

**A strategy is a coherent set of policies, programmes, and projects which defines the path to be pursued towards the achievement of a set of goals. The strategy provides the framework for plans and reconciles the trade-offs required when scarce resources are devoted to the pursuit of multiple goals.**

The national U5MR is a particularly sensitive indicator, with its average annual rate of reduction a corresponding measurement of the rate of progress. In addition, other basic indicators, such as the rates of literacy, life expectancy, access to water and sanitation, and nutrition surveillance data, etc., should be strengthened, refined, and used to monitor progress towards the achievement of the goals of the Fourth Development Decade.

National capacity-building

A fundamental aim of development co-operation is to help countries and communities help themselves. External co-operation must not create or perpetuate dependency, but must enhance self-reliance. Accordingly, external aid must emphasize institution building and infrastructure development. Policies and programme approaches promoted by all donors, lenders, and partners in development co-operation, including UNICEF, must be tested not only for their effectiveness in tackling pressing current problems, but also for their potential to lay the foundation for long-term self-reliant development.

Focus on the Doable

The need to build infrastructures for long-term development is often used as justification for not investing in what is currently feasible. With human

capital the most important factor for development of a nation, support of the many readily achievable goals for child survival and development must be defended as productive investment for national development, not just as essential consumption for social welfare.

**Collaboration with other United Nations agencies**

Increasingly, the United Nations development system is focusing on human development as the centrepiece of its contribution to the international development strategy for the 1990s. It is imperative that all parts of the United Nations system collaborate not only to promote human development goals and strategies, but also to advocate broader macro-economic goals and strategies in support of the human goals for the decade.

Besides the political commitment of governments and co-ordinated support by United Nations agencies, the success of the goals for children and development in the 1990s is also critically dependent on the active support of bilateral donors, regional institutions, and NGOs. Building effective partnership among these organizations is another key task for the decade.

**Further reading**

*Human Development Report 1990.* Published for UNDP by Oxford University Press. New York and Oxford. 1990.

*Health Research: Essential Link to Equity in Development.* Published for the Commission on Health Research for Development by Oxford University Press. New York and Oxford. 1990.

*Action at the Grassroots: Fighting Poverty and Environmental Decline,* by Alan B. Durning. Worldwatch Paper No.88. Washington. Jan.1989.

*Communicating for Health: Agent for Change.* Joint UNICEF and WHO publication. UNICEF. New York. 1988.

*New Directions in Family Planning Communication: 12 Predictions for the 1990s,* by Phyllis T. Piotrow and Jose G. Rimon II. The Johns Hopkins University Center for Communication Programs. Occasional Paper Series. No.1. Baltimore. Feb.1990.

BLANK

PAGE

# *Reducing mortality among children under five*

## In brief

***The Goal: Between 1990 and the year 2000, reduction of the infant mortality rate (IMR) and the under-five mortality rate (U5MR) in all countries by one third, or to 50 and 70 per 1,000 live births, respectively, whichever is less.***

**Every day, 40,000 children below the age of five die. The immediate causes are specific illnesses such as diarrhoea, acute respiratory infections (ARI), measles, tetanus, etc. But malnutrition, lack of access to safe water, sanitation, and primary health care, and ignorance and poverty are all major factors in these deaths. Thus, the achievement of this very ambitious goal will require, along with such proven life savers as immunization and oral rehydration therapy (ORT), a commitment by world leaders to sustainable human development in all its dimensions.**

The goal of reducing infant and under-five mortality by one third (to 50 and 70 deaths respectively per 1,000 live births, whichever is less) is one that, in a way, reflects the cumulative impact of all the other goals. Lowered mortality is an indicator of overall well-being as well as a reflection of improvements in health. Progress towards lowering malnutrition, improving access to water and sanitation, and ensuring universal basic education will help lower infant and child mortality.

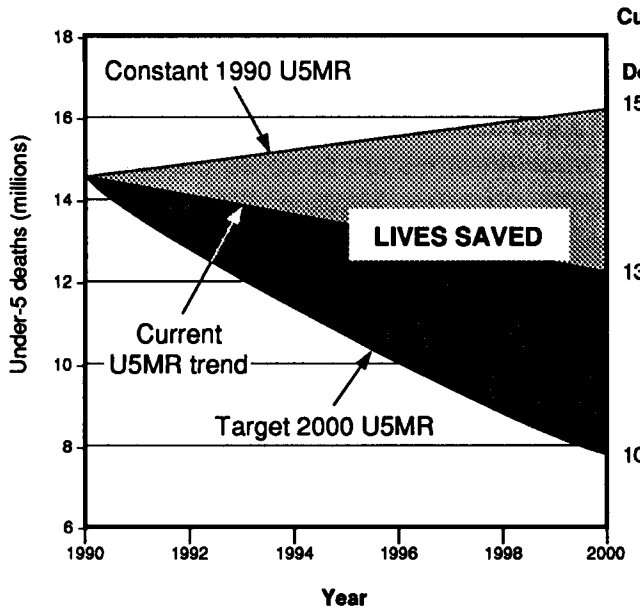
It is unconscionable that 40,000 children die every day. Reaching the goal will mean that "only" 21,000 will die every day, still a frightening figure. But if the goal is reached 28 million fewer child deaths will have occurred by the year 2000 than if the current mortality trend is allowed to continue.

As recently as 1960, the probability of death before the age of five (the under-five mortality rate or U5MR) was one in five for the world as a whole and almost three in ten for most of Africa and South Asia. Significant progress has been made since then.

The world's U5MR has been reduced by nearly half since 1960, thanks to general improvements in health and social services, education, and economic well-being for many families, though not for all. If this downward trend in under-five mortality continues, we can expect that the annual child death toll will drop from the current 14.6 million to 12.2 million in the year 2000. The joint goal adopted by WHO, UNFPA, AND UNICEF and now proposed for the World Summit for Children would lower this toll even further, to 7.8 million.

## Saving children's lives in the 1990s

*(Under-5 mortality rate = U5MR)*




*Source: UNICEF, based on United Nations Population Division estimates*

**Cummulative (millions)**
**1990-2000**

| Deaths | Lives saved |
|---|---|
| 155 | |
| 133 | 50 |
| 105 | |

**Target 2000 U5MR**

Between 1990 and the year 2000, reduction of under-5 mortality rate in all countries by one third or to 70 per 1,000 live births, whichever is less.

In the last decade, economic progress came to a halt in most of Africa and Latin America, yet the U5MR continued to decline (though more slowly than it declined in other developing countries). Thanks in part to the massive promotion and use of life-saving technologies, notably immunization and ORT, many deaths were prevented, despite the worsening economic conditions.

There are limits, however, to what can be achieved by such technological breakthroughs alone. There are indications, for instance, that malnutrition, especially in Africa, increased during this same period, and the AIDS pandemic threatens to undo much of the progress made. It is doubtful, therefore, whether the historic decline of U5MR can be sustained and accelerated without attacking mortality on a broader front.

Progress in immunizing children, conquering measles, increasing the use of ORT, and bringing effective treatment of pneumonia to the community level must continue. In the 1990s, however, child mortality has to be viewed as a problem that transcends the health sector alone. It must be seen as a problem of nutrition, education, water supply and sanitation, and ultimately of sustainable human development in all its dimensions.

### The consequences of high child mortality

Parents in the world's Least Developed Countries still face the prospect that one out of every five children born to them will die before the age of five. A major objective of the Summit is precisely to rid the world of this spectre. The cost of child mortality is enormous, in grief, in human potential lost, in the apathy and fatalism it breeds.

The tendency for couples to have more children to compensate for expected child deaths destroys women's health and their hopes for education and economic advancement, not to mention the impact it has on population growth. High rates of child mortality are in every way part of a package of underdevelopment: they help create it, they feed it, and they are its surest indicator.

### Why millions die

The reasons for infant and child mortality are numerous and multi-tiered. The immediate cause of a child's death is usually a disease, often preventable or readily treated with low-cost interventions. The graph on the next page shows the approximate breakdown of immediate causes of child deaths according to WHO.

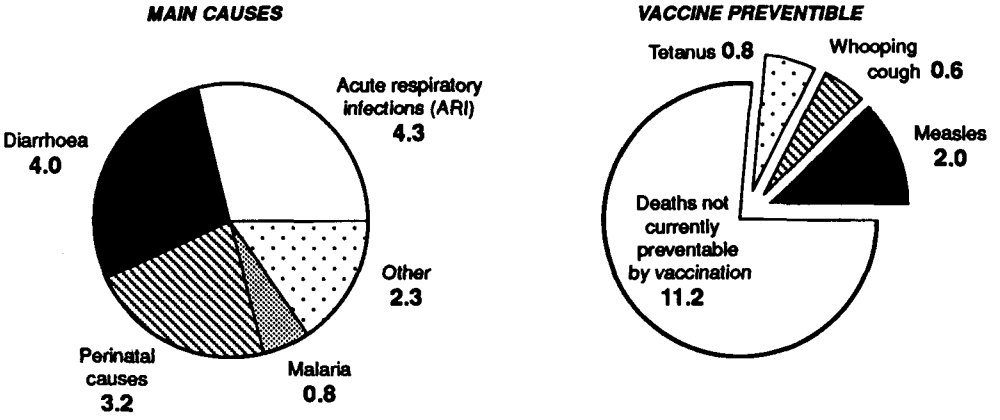
About 3.4 million or 23 per cent of the 14.6 million child deaths occurring annually are preventable by vaccination. Nearly 70 per cent of the 4 million deaths from diarrhoea could be prevented by ORT. Of the 2.8 million deaths from ARI that are not vaccine preventable, most are due to pneumonia, which in many cases can be prevented by timely treatment with antibiotics.

Behind these immediate causes of death, however, lie factors such as malnutrition, ignorance, and, ultimately, poverty. Malnutrition, for instance, is associated in about one third of all child deaths. Malnourished children lack the defenses well nourished children have, and succumb to diseases such as measles that well nourished children would survive.

Illiteracy, ignorance of basic hygiene, and lack of access to water and sanitation are other underlying causes of child mortality that increase the risk of infection and limit the capacity to deal with it. All these in turn are symptoms of poverty and inadequate human development. Ways of dealing with these problems within each sector are discussed in many other chapters of this sourcebook. To reduce mortality as a whole, however, it is important to emphasize the intersectoral nature of the

## Annual child deaths

**Developing countries, around 1985**
(in millions)




Measles and whooping cough vaccines prevent mainly ARI deaths.
Measles vaccine also prevents diarrhoea deaths.
Tetanus vaccine prevents perinatal deaths.

*Source: World Health Statistics Quarterly 43.2 (1990) in preparation.*

problem and the need for the services of various sectors to converge in time and place, as needed by people with multifaceted problems in concrete circumstances.

Mortality is mulitsectoral

The need for actions in different sectors to converge on a single problem can be illustrated by the example of the third most important killer of children in the world after ARI and diarrhoea: perinatal causes. Several measures discussed in the chapter on maternal mortality can help reduce perinatal and neonatal deaths in children as well. But simply immunizing women against tetanus, providing them with trained birth attendants and services for referral, and transporting high risk cases will not be enough to combat all deaths due to perinatal causes.

Low birth weight, for instance, is an important perinatal factor that in turn depends on maternal nutrition in many cases. Maternal health and maternal nutrition improve when women are educated and have adequate nourishment and when their work burden is reduced through access to a safe water supply and cooking fuel. Only through action in all these sectors will the number of infant deaths due to perinatal causes be brought down to levels that might be considered tolerable.

As services need to converge on a family and complement each other, they also need to be universal. Many population groups are easily forgotten in the design of service coverage: those living in settlements of less than 500 inhabitants, for example, or ethnic minorities, nomads, populations displaced by war and other disasters, those living in remote areas whom it is difficult to reach, or those living in the slums and shanty towns of major cities—all must be included if a serious and lasting impact is to be achieved on the problems of infant and child mortality.

### Constraints

The principal obstacles to lowering infant and child mortality are poverty and the lack of resources to provide primary health care, and basic education, nutrition, and water and sanitation services. The costs per capita of providing these are discussed in the various chapters of this volume and are not unreasonable; the world as a whole could afford them. The difficulties are assuring that available resources are put to optimal use, attracting the additional resource transfers needed, and assuring the revitalization of economic growth to sustain progress. These are discussed in the concluding chapters of this volume.

**In the 1990s, child mortality has to be viewed as a problem that transcends the health sector alone. It must be seen as a problem of nutrition, education, water supply and sanitation, and ultimately of sustainable human development in all its dimensions.**

Another serious potential obstacle is the spread of new diseases such as AIDS. Efforts must be made to restrict the transmission of AIDS, as proposed in the chapter on the disease.

And, finally, uncontrolled population growth interacting with poverty and the limitations of the physical environment will make it more difficult to reduce mortality. The promotion of family planning must be part of the overall effort as set forth in the chapter on child survival and population growth, and the chapter on child spacing, in this sourcebook.

### Measuring mortality

Decisions concerning what to do about the problem require clear and reliable data on mortality and the risk factors associated with it. Registers of vital statistics tend to be weakest precisely where mortality is highest. Efforts to strengthen vital statistics are under way and deserve greater support. Considerable progress has also been made over the past decade in strengthening survey capability for measuring infant and child mortality in decentralized and relatively low-cost ways. Measuring mortality by specific causes (or even by causes as perceived by parents through a

technique called "verbal autopsy") has been done less widely, but experience is growing in this field as well.

Once national officials at central, provincial, and district levels begin receiving timely and credible information on how many children are dying and what is killing them, they can focus their resources more efficiently on those programmes and actions that will prevent such deaths. This is why the strengthening of national and sub-national record keeping and measurement capability is so important.

Another benefit of improved child mortality monitoring is the use that can be made of such information for advocacy and social mobilization. More valuable than a single IMR or U5MR for a country as a whole are up-to-date mortality figures disaggregated to show those parts of the country or those groups within the country where mortality is highest. Public attention, where appropriate, can thus be called to such disparities and priority assigned to those places and groups.

## A world-wide commitment

Because the goal of reducing infant and child mortality depends on the achievement of so many other goals, it is perhaps the most ambitious one of all. The UNDP's recently published *Human Development Report* points out that if progress continues only at the rates occurring in past years, some 23 countries will not attain the target until after 2050.

The gentle downward slope of current trends must be bent to a steeper angle. Demographic trends do not change easily, but they can be changed. Perhaps it is only with a world-wide commitment at the highest levels, for which the World Summit for Children provides a unique opportunity, and a subsequent mobilization of all the forces of society to accelerate the decline in infant and child mortality, that this goal, whose attainment would be the crowning achievement of the decade, can be reached.

## Further reading

*The State of the World's Children 1989*. Published for UNICEF by Oxford University Press. New York. 1989.

BLANK

PAGES

# INFANT MORTALITY AND MORTALITY AMONG CHILDREN UNDER FIVE

| | Infant mortality rate* | | Under 5 mortality rate** | | U5MR average annual reduction rate (%) |
|---|---|---|---|---|---|
| | 1990 | 1988 | 1990 | 1988 | 1980-88 |
| **LATIN AMERICA & CARIBBEAN** | **56** | **46** | **82** | **68** | **2.9** |
| Argentina | 38 | 32 | 46 | 37 | 2.7 |
| Bolivia | 131 | 109 | 207 | 172 | 2.3 |
| Brazil | 75 | 62 | 103 | 85 | 2.4 |
| Chile | 34 | 19 | 43 | 26 | 6.3 |
| Colombia | 52 | 46 | 78 | 68 | 1.7 |
| Costa Rica | 25 | 18 | 31 | 22 | 4.3 |
| Cuba | 21 | 15 | 27 | 18 | 5.1 |
| Dominican Rep. | 79 | 64 | 102 | 81 | 2.9 |
| Ecuador | 76 | 62 | 107 | 87 | 2.6 |
| El Salvador | 76 | 58 | 110 | 84 | 3.4 |
| Guatemala | 76 | 58 | 130 | 99 | 3.4 |
| Guyana | 65 | 56 | 82 | 71 | 1.8 |
| Haiti | 133 | 116 | 197 | 171 | 1.8 |
| Honduras | 68 | 68 | 140 | 107 | 3.4 |
| Jamaica | 23 | 18 | 29 | 22 | 3.5 |
| Mexico | 56 | 46 | 83 | 68 | 2.5 |
| Nicaragua | 84 | 61 | 132 | 95 | 4.1 |
| Panama | 29 | 23 | 43 | 34 | 2.9 |
| Paraguay | 47 | 42 | 70 | 62 | 1.5 |
| Peru | 102 | 87 | 144 | 123 | 2.0 |
| Trinidad & Tobago | 25 | 20 | 29 | 23 | 2.9 |
| Uruguay | 37 | 27 | 43 | 31 | 4.1 |
| Venezuela | 41 | 36 | 50 | 44 | 1.6 |
| **MIDDLE EAST & NORTH AFRICA** | **89** | **68** | **131** | **93** | **3.7** |
| Algeria | 100 | 73 | 147 | 107 | 4.0 |
| Egypt | 110 | 83 | 164 | 125 | 3.4 |
| Iran, Islamic Rep. | 89 | 55 | 130 | 90 | 4.6 |
| Iraq | 80 | 68 | 110 | 94 | 2.0 |
| Jordan | 59 | 43 | 80 | 57 | 4.2 |
| Kuwait | 28 | 19 | 34 | 22 | 5.4 |
| Lebanon | 48 | 39 | 62 | 51 | 2.4 |
| Libyan Arab Jamahiriya | 102 | 80 | 150 | 119 | 2.9 |
| Morocco | 103 | 80 | 152 | 119 | 3.1 |
| Oman | 88 | 40 | 146 | 64 | 10.3 |
| Saudi Arabia | 92 | 70 | 131 | 98 | 3.6 |
| Syria | 64 | 47 | 87 | 64 | 3.8 |
| Tunisia | 79 | 58 | 113 | 83 | 3.9 |
| Turkey | 106 | 74 | 133 | 93 | 4.5 |
| United Arab Emirates | 35 | 25 | 43 | 32 | 3.7 |
| Yemen | 137 | 115 | 227 | 190 | 2.2 |
| Yemen, Dem. | 142 | 118 | 236 | 197 | 2.3 |
| **AFRICA SOUTH OF THE SAHARA** | **121** | **105** | **203** | **176** | **1.7** |
| Angola | 155 | 173 | 272 | 292 | -0.9 |
| Benin | 125 | 109 | 211 | 185 | 1.6 |
| Botswana | 79 | 66 | 110 | 92 | 2.2 |
| Burkina Faso | 155 | 137 | 265 | 233 | 1.6 |
| Burundi | 127 | 111 | 215 | 188 | 1.7 |
| Cameroon | 107 | 93 | 176 | 153 | 1.8 |
| Central African Rep. | 143 | 131 | 244 | 223 | 1.1 |
| Chad | 148 | 131 | 253 | 223 | 1.6 |
| Congo | 83 | 72 | 132 | 114 | 1.8 |
| Côte d'Ivoire | 110 | 95 | 166 | 142 | 2.0 |
| Ethiopia | 154 | 153 | 260 | 259 | 0.1 |
| Gabon | 117 | 102 | 194 | 169 | 1.7 |
| Ghana | 100 | 89 | 165 | 146 | 1.5 |
| Guinea | 165 | 146 | 281 | 248 | 1.6 |
| Kenya | 84 | 71 | 133 | 113 | 2.0 |
| Lesotho | 117 | 99 | 161 | 136 | 2.1 |
| Liberia | 101 | 86 | 173 | 147 | 2.0 |
| Madagascar | 140 | 119 | 216 | 184 | 2.0 |
| Malawi | 170 | 149 | 300 | 262 | 1.7 |
| Mali | 185 | 168 | 323 | 292 | 1.3 |
| Mauritania | 143 | 126 | 249 | 220 | 1.6 |
| Mauritius | 33 | 22 | 42 | 29 | 4.6 |
| Mozambique | 157 | 173 | 258 | 298 | -1.8 |
| Namibia | 121 | 105 | 202 | 176 | 1.7 |
| Niger | 151 | 134 | 258 | 228 | 1.6 |
| Nigeria | 119 | 104 | 198 | 174 | 1.6 |
| Rwanda | 136 | 121 | 231 | 206 | 1.4 |
| Senegal | 120 | 80 | 205 | 136 | 5.1 |
| Sierra Leone | 172 | 153 | 300 | 266 | 1.5 |
| Somalia | 146 | 131 | 247 | 221 | 1.4 |

# INFANT MORTALITY AND MORTALITY AMONG CHILDREN UNDER FIVE

| | Infant mortality rate* | | Under 5 mortality rate** | | U5MR average annual reduction rate (%) |
|---|---|---|---|---|---|
| | 1980 | 1988 | 1980 | 1988 | 1980-88 |
| **AFRICA SOUTH OF THE SAHARA (continued)** | | | | | |
| South Africa | 89 | 71 | 120 | 95 | 2.9 |
| Sudan | 124 | 107 | 210 | 181 | 1.9 |
| Tanzania | 120 | 105 | 201 | 176 | 1.7 |
| Togo | 106 | 93 | 176 | 153 | 1.8 |
| Uganda | 113 | 102 | 187 | 169 | 1.3 |
| Zaire | 105 | 83 | 174 | 138 | 2.9 |
| Zambia | 91 | 79 | 146 | 127 | 1.7 |
| Zimbabwe | 83 | 71 | 132 | 113 | 1.9 |
| **ASIA** | **81** | **60** | **114** | **85** | **3.0** |
| Afghanistan | 183 | 171 | 321 | 300 | 0.9 |
| Bangladesh | 132 | 118 | 211 | 188 | 1.4 |
| Bhutan | 143 | 127 | 222 | 197 | 1.5 |
| China | 40 | 31 | 56 | 43 | 3.3 |
| Hong Kong | 11 | 8 | 14 | 10 | 4.2 |
| India | 118 | 96 | 180 | 149 | 2.4 |
| Indonesia | 100 | 87 | 145 | 119 | 2.5 |
| Kampuchea | 211 | 127 | 330 | 199 | 6.3 |
| Korea, Dem. | 32 | 24 | 43 | 33 | 3.3 |
| Korea, Rep. | 32 | 24 | 43 | 33 | 3.3 |
| Laos | 128 | 109 | 189 | 159 | 2.2 |
| Malaysia | 31 | 24 | 42 | 32 | 3.4 |
| Mongolia | 57 | 44 | 77 | 59 | 3.3 |
| Myanmar | 85 | 69 | 118 | 95 | 2.7 |
| Nepal | 143 | 127 | 222 | 197 | 1.5 |
| Pakistan | 125 | 108 | 192 | 166 | 1.8 |
| Papua New Guinea | 79 | 57 | 111 | 81 | 3.9 |
| Philippines | 52 | 44 | 86 | 73 | 2.1 |
| Singapore | 11 | 9 | 15 | 12 | 2.8 |
| Sri Lanka | 43 | 32 | 58 | 43 | 3.7 |
| Thailand | 52 | 38 | 67 | 49 | 3.9 |
| Viet Nam | 83 | 63 | 116 | 88 | 3.5 |
| **INDUSTRIAL COUNTRIES** | **13** | **9** | **17** | **12** | **3.9** |
| Albania | 47 | 28 | 58 | 34 | 6.7 |
| Australia | 11 | 9 | 14 | 10 | 4.2 |
| Austria | 14 | 8 | 18 | 10 | 7.4 |
| Belgium | 12 | 10 | 17 | 13 | 3.4 |
| Bulgaria | 29 | 15 | 25 | 20 | 2.8 |
| Canada | 10 | 7 | 13 | 8 | 6.1 |
| Czechoslovakia | 17 | 12 | 21 | 15 | 4.2 |
| Denmark | 8 | 8 | 11 | 11 | 0.0 |
| Finland | 8 | 6 | 9 | 7 | 3.1 |
| France | 10 | 8 | 13 | 10 | 3.3 |
| German Dem. | 12 | 8 | 17 | 12 | 4.4 |
| Germany, Fed. | 13 | 8 | 17 | 10 | 6.6 |
| Greece | 20 | 13 | 23 | 18 | 3.1 |
| Hungary | 23 | 17 | 26 | 19 | 3.9 |
| Ireland | 12 | 7 | 15 | 9 | 6.4 |
| Israel | 16 | 11 | 18 | 14 | 3.1 |
| Italy | 15 | 10 | 18 | 11 | 6.2 |
| Japan | 8 | 5 | 12 | 8 | 5.1 |
| Netherlands | 9 | 8 | 10 | 8 | 2.8 |
| New Zealand | 13 | 10 | 15 | 12 | 2.8 |
| Norway | 8 | 8 | 10 | 10 | 0.0 |
| Poland | 21 | 16 | 24 | 18 | 3.6 |
| Portugal | 25 | 14 | 29 | 17 | 6.7 |
| Romania | 28 | 22 | 35 | 28 | 2.8 |
| Spain | 13 | 9 | 17 | 12 | 4.4 |
| Sweden | 8 | 6 | 9 | 7 | 3.1 |
| Switzerland | 9 | 7 | 11 | 8 | 4.0 |
| United Kingdom | 13 | 9 | 16 | 11 | 4.7 |
| USSR | 27 | 25 | 33 | 32 | 0.4 |
| USA | 13 | 10 | 16 | 13 | 2.6 |
| Yugoslavia | 32 | 25 | 36 | 28 | 3.1 |

Source: The State of the World's Children 1990, Tables 1 and 9, and UN Population Division.
(For explanations and qualifications of specific figures, see notes there.)

* Annual number of deaths of infants under one year of age per 1,000 live births.
** Annual number of deaths of children under five years of age per 1,000 live births.

Figures for country groupings are median values.

BLANK

PAGE